STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance Survey completed on April 13, 2023, it was determined Barnes Kasson County Hospital Skilled Nursing Facility was not in compliance with the following requirements of 42 CFR, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0584 SS=D		F 0584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: | (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 1 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	1. Identified Housekeeping and concerns were resolved at time of survey, Maintenance concerns identified in process of being addressed. 2. Education was provided to Housekeeping and Maintenance supervisor regarding requirements for safe/clean/comfortable homelike environment. 3. Education being provided with Housekeeping department regarding compliance with regulations along with review of cleaning policies and procedures. Education being provided with Maintenance department regarding compliance with regulations along with review of safety/cleaning policies and procedures. 4. An audit will be completed by Housekeeping supervisor/designee to ensure compliance with regulation 3x weekly for 12 weeks with results forwarded and reviewed at QAPI committee meetings. An audit will be completed by Maintenance supervisor/designee to ensure compliance with regulation 3x	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 2 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	weekly for 12 weeks with results forwarded and reviewed at QAPI committee meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 3 Based on observations and staff interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a clean and sanitary environment in resident rooms and common areas in the facility. Findings include: Observations of resident room 213 during an environmental tour of the facility on April 11, 2023, at approximately 10:40 AM revealed a brown substance smeared on the wall near the base board located to the right of the resident's bed. An accummulation of leaves, cobwebs and dirt was observed between the window screen and window in the room. Observation of resident lounge/visiting area revealed a large accumulation of spiderwebs in right hand corner of the window located near the ceiling and webs and dirt in the left hand corner of the same window.	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0584 SS=D	Continued from page 4 Observation of resident room 219 on April 11, 2023, at 10:00 AM, revealed that the resident safety mats on the floor were heavily soiled with dirt and stained with a dried tan colored substance. Further observation of the room revealed that there was a rotting banana atop the night stand in front of the television. Observation of room 201 on April 12, 2023, at approximately 10:30 AM revealed that the heating/AC unit access door was unlatched and open revealing a heavy build of white lint. Interview with the Nursing Home Administrator (NHA) on April 13, 2023, at approximately 2 PM confirmed that the resident environment was to be maintained in a clean and sanitary manner. 28 Pa. Code 207.2(a) Administrator's Responsibility.	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	483.10(e)(1), 483.12(a)(2) Right to be Free from Chemical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by:	F 0605	1. The facility cannot retroactively correct deficient practice for resident 19. Medication regime review completed by MD. 2. Staff will review during Behavior Monitoring meetings potential underlying causes for residents' behaviors and attempt interventions to mitigate same. The prescribing practitioner will demonstrate ongoing re-evaluation of need for psychoactive medications 3. Facility staff will be educated on alternate interventions developed to manage or mitigate residents' behaviors. MD's will be educated on ongoing re-evaluation of need for psychoactive medications. 4. An audit will be completed x 12 weeks to evaluate least restrictive alternative utilized along with ongoing reevaluation of the need for medications.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/08/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**
STATE LICENSE NUMBER: **020502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 6 Based on observations and clinical record review it was determined that the facility failed to ensure that residents were free of chemical restraints used to most readily control resident behavior for one resident out 13 sampled residents (Resident 19). Findings include: A review of the clinical record revealed that Resident 19 was admitted to the facility on February 17, 2020, with diagnoses to include dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) anxiety and chorea-like movements (Chorea is a movement disorder that occurs in many different diseases and conditions. Dozens of	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 7 genetic conditions, autoimmune and infectious diseases, endocrine disorders, medications and even pregnancy can have chorea as a symptom. Treatment is based on cause of the chorea). A significant change MDS Assessment (Minimum Data Set - a federally mandated assessment completed periodically to plan resident care) dated March 27, 2023, revealed that Resident 19 was moderately cognitively impaired and exhibited physical and verbal behaviors. A review of Resident 19's monthly behavior tracking flow records dated August 2022 through April 2023 revealed that the resident displayed behaviors to include anxiety, restlessness, verbal aggression and throwing objects.	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 8 A review of the resident's current care plan for the resident's problem of "behaviors" initiated February 20, 2020 revealed that the "Resident requires psychosocial interventions, receives Venlafaxine (an antidepressant medication), Buspirone (an antianxiety medication), Xanax (a benzodiazepine, anxiety medication) and Depakote (an antiseizure medication used as a mood stabilizer). Resident 19 gets frustrated with staff if they do not immediately understand her or know what she wants. She can be needy at times, and occasionally is restless, verbally aggressive, yells and throws objects." Care planned interventions were to administer medications as per physician orders, encourage activity involvement (type of activity preferred by the resident was not identified) and socialization with	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 9 others, seek Physician/Psychological consult as needed for medication and behavioral management, provide reading material for the resident and provide one on one if needed. A physician order, nurses notes and monthly Medication Administration Records dated from August 26, 2022 through September 12, 2022, revealed that the resident received Klonopin (an antianxiety agent, Benzodiazepines/Anticonvulsant) ODT (dissolves in the mouth) 0.25 mg, one by mouth twice a day. The medication was increased September 12, 2023 to Klonopin (ODT) 0.5 mg in the AM and 0.25 mg at HS (at bedtime). Nurses notes dated November 28, 2022 at 11:19 A.M. revealed that the certified	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 10 registered nurse practitioner was aware of the resident's increased behaviors and safety concerns. The CRNP discontinued the Klonopin ODT dose of .5 mg in the AM and .25 mg in the PM and ordered the start Klonopin ODT 0.5 mg by mouth twice a day. A review of nurses notes dated December 14, 2022 at 2:41 P.M. revealed "The nurse was walking down the hall, observed the resident sitting on the edge of her chair. The chair flipped and she fell to the floor. Nursing assessed the resident and no injuries were noted." Nurses note dated December 14, 2023 at 12:50 P.M. revealed that the nursing notified the CRNP that the resident was displaying continued outbursts and yelling. Nursing noted that Resident 19	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 11 continued to throw objects and swearing. The CRNP ordered an increase in the resident's dose of Celexa (an antidepressant medication) to 40 mg by mouth every day and also increased the resident's dose of Klonopin (ODT) to .5 mg, by mouth to three times a day. Resident 19 was admitted to the hospital December 15, 2022, and readmitted to the facility on December 19, 2022. The order for Klonopin (ODT) .5 mg TID was not re-ordered upon the resident's readmission to the facility. Upon readmission to the facility on December 19, 2022, the physician ordered Buspirone HCL (antianxiety medication) 10 mg tablet, give one by mouth twice daily for anxiety. On January 5, 2023 at 12:30 PM, nursing	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 12 called the physician to Resident 19's room. Resident 19 was flailing her arms and screaming at staff. Nursing noted that the resident was unable to sit still at that time. Redirection given, food and beverages offered, change of scenery given, one to one preformed. Resident continues to flail and scream at staff. New order noted, Haldol (an antipsychotic medication) 1 mg by mouth, give now and Haldol 1 mg by mouth twice a day. A review of a monthly medication administration record (MAR) revealed that Resident 19 received Haldol 1 mg BID daily from January 5, 2023, through January 18, 2023. A review of nurses notes dated January 18, 2023, at 2:23 PM revealed that nursing	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 13 noted that Resident 19 continued with agitation, restlessness and the physician was made aware. A new order was noted to discontinue the Haldol and order Depakote (an antiseizure medication sometimes used as a mood stabilizer) 250 mg by mouth three times a day. A nurse's note dated February 8, 2023 at 9:57 A.M. revealed that Resident 19 displayed increased anxiety and restlessness. Nursing noted that the resident was yelling out and throwing things. Refused meals and liquids this morning due to increased anxiety. Re approached. Dark area provided. Resident taken for a walk. No good effects noted. The physician was notified and a new order noted for Xanax (an antianxiety medication) 0.5 mg, take 2 tabs by mouth now and Xanax 0.5 mg,	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 14 take 2 tabs by mouth every day. Nursing noted on February 9, 2023 at 2:33 P.M., that Resident 19 displayed increased anxiousness and restless movements this afternoon. Refused lunch. Yelling out. Dark quiet area provided. No good effects noted and the physician was made aware. A new order was noted for Xanax 0.5 mg, give 2 tabs by mouth now. A nurses note dated February 10, 2023 at 2:49 revealed that Resident 19 was extremely agitated and unruly, cussing, flailing her arms and legs. Staff placed the resident in a broda chair. The resident was repeatedly trying to bounce in her chair and get out of her chair. "Resident very animated, will not calm down."	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 15 Nursing noted on February 10, 2023 at 4:36 A.M., that Resident 19 displayed unrelenting episodes of agitation and restlessness with acting out and inability to calm down after repeated measures were tried. Nursing noted that the resident has an indwelling urinary catheter and was provided catheter care. Resident does not appear to understand about the catheter and lack of need to be toileted for urination although this was repeatedly verbalized to her. Resident was put into her broda chair and placed at the nurses station but kept trying to fling herself out of the chair. Nursing called the physician regarding the resident's behaviors and the physician ordered Xanax 0.5 mg by mouth now. Resident 19 was admitted to the acute care hospital and readmitted to the facility	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 16 on February 14, 2023. Upon readmission the physician ordered Xanax .5 mg by mouth every 8 hours as needed for 14 days. A pharmacy request to the physician dated February 20, 2023, revealed that the pharmacist requested that the physician re-evaluate the resident's need for Xanax 0.5 mg, every 8 hours by mouth as needed. The physician re-ordered Xanax 0.5 mg every 8 hours as needed every 14 days beginning February 20, 2023. On March 18, 2023, the pharmacist requested that the physician re-evaluate the resident's need for Xanax 0.5 mg, every 8 hours by mouth as needed. The pharmacist noted "Please note that renewal of an as needed order requires a physician explaination	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 17 and documentation. Based on the narcotic order sign out sheet, it may be appropriate to make Xanax a straight order at bedtime." The physician response was noted by the CRNP dated March 22, 2023, noting Xanax changed to straight order at 2 A.M for anxiety disorder. Nurses notes dated March 21, 2023 at 3:58 A.M. revealed that PRN Xanax 0.5 mg tablet given after continuous attempts to calm resident. Nurses notes dated March 21, 2023, at 1:33 PM revealed that the 14 day, as needed, Xanax order was reevaluated by Physician with a new order noted, Xanax 0.5 mg by mouth every day at 2 A.M.	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 18 There was no documented evidence at the time of the survey of a documented physician evaluation regarding the resident's need for the administration of the Xanax at 2 AM daily. In response to the resident's behaviors nursing staff notified the physician/physician extender and multiple psychoactive medications were ordered and administered to this resident concurrently. There was no documented evidence at the time of the survey that the facility had used the least restrictive alternative for the least amount of time, that the prescribing practitioners had conducted ongoing re-evaluation of the need for the medications and consistently demonstrated these drugs were not used	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 19 for staff convenience to most readily control the resident's behavior with least amount of staff effort. The facility administered multiple psychotropic drugs including Klonopin, Buspar, Depakote, Haldol, and Xanax to control the resident's behaviors. An interview with the Director of Nursing on April 13, 2023, at approximately 12:00 PM confirmed that the resident's clinical record lacked documented evidence that the staff and prescribing practitioners had identified and addressed to the extent possible, potential underlying causes for the resident's behaviors and had attemped to rule potential causes for the resident's behaviors to include possible physical causes such as pain or potential adverse consequences associated with the	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 20 resident's current medication regimen or possible environmental factors, such as staffing levels, over stimulating noise or activities, under stimulating activities, alteration in the resident's customary location or daily routine, temperature of the environment, and crowding to ensure the medical necessity of the administration of these psychoactive drugs. 28 Pa Code 211.12 (a)(c)(d)(1)(3)(5) Nursing services 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.8 (b) Use of restraints 28 Pa. Code 211.2(a) Physician Services	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0605 SS=E	Continued from page 21 .	F 0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0661 SS=D	483.21(c)(2)(i)-(iv) Discharge Summary §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by:	F 0661	1. The facility cannot retroactively correct deficiency in relation to resident 42. 2. Resident discharge summary policy and form updated to include recapitulation of resident stay including nursing discharge instructions, review of therapy services received while a resident at the facility, and discharge summary, dietary discharge instructions, social services summary while a resident at the facility and corresponding discharge instruction, upcoming physician appointments and a summary of activities noted during the stay at the facility. 3. Nursing staff will be educated regarding changes to discharge summary. 4. NHA/Designee will audit discharge summaries for recapitulation of resident stay, results reviewed at QAPI.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0661 SS=D	Continued from page 23 Based on a review of clinical records and staff interview it was determined that the facility failed to include a recapitulation of the residents' stay in the discharge summary of one of two closed records reviewed (Resident 42). Findings include: A review of the closed clinical record revealed that Resident 42 was admitted to the facility on November 17, 2022, with diagnoses impaired ambulation and generalized weakness and after care and therapy post hospitalization. The resident was discharged to an assisted living facility on January 20, 2023. A nursing note dated January 20, 2023 at 11:20 AM revealed that Resident 42 was picked up at the facility by her daughter,	F 0661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0661 SS=D	Continued from page 24 noting that the resident was going to a personal care home. There was no documented evidence of a recapitulation of the resident's stay to include, nursing discharge instructions, a review of therapy services received while a resident at the facility, and a discharge summary, dietary discharge instructions, social services summery while a resident at the facility and corresponding discharge instructions, any upcoming physicians appointments and a summary of activities noted during the stay at the facility. An interview with the Nursing Home Administrator on April 13, 2023 at approximately 1 p.m., confirmed that a recapitulation of Resident 42's stay had not been completed.	F 0661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0661 SS=D	Continued from page 25 28 Pa. Code 211.5 (f) Clinical records. 28 Pa. Code 201.25 Discharge policy	F 0661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0661 SS=D	Continued from page 26	F 0661		
F 0689 SS=G		F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 27 483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 0689	1. Potential accident hazards identified during inspection were removed from resident room by Maintenance. The facility cannot retroactively correct deficiency as it relates to resident. Resident 10 and Resident 23. Resident 10's plan of care clarified for fall prevention approaches. Resident 10 and 23 received a therapy screening for ambulation and recommendations to prevent further falls. 2. Education was provided to Maintenance supervisor regarding requirements for safe environment. Education provided to nursing staff regarding fall policy. Education to activity director regarding supervision in dining room. 3. Maintenance staff being education by supervisor regarding requirements for safe environment. Fall/safety care plans will be reviewed quarterly, or s/p fall to assure approaches appropriate and match CNA assignment. Staff will alert investigation coordinator of any preventative measures put into place so that appropriate	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

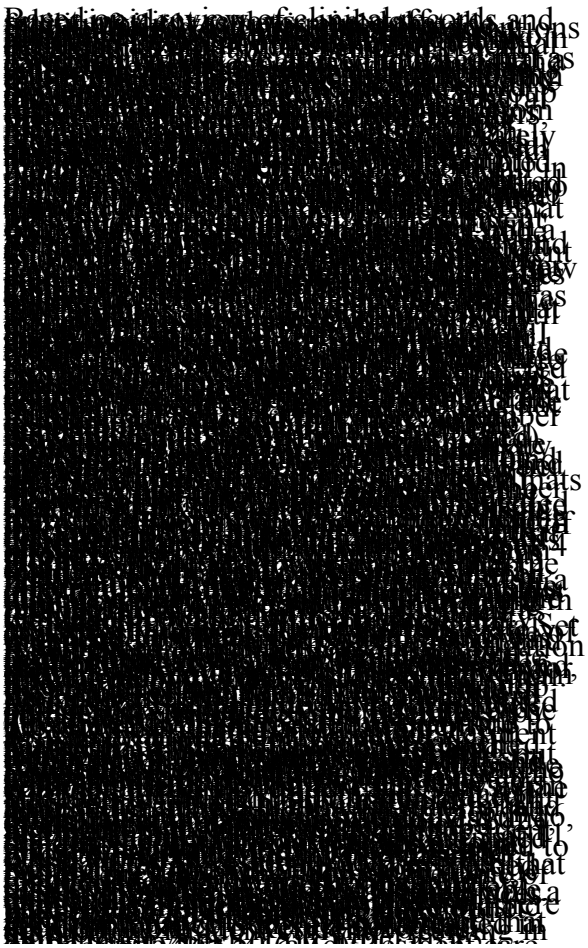
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 28	F 0689	intervention can be care planned. Education by activity director to staff about supervision of SNF residents in dining room. 4. An audit will be completed by Maintenance supervisor to ensure compliance with regulation 3x weekly for 12 weeks with results forwarded and reviewed at QAPI committee meetings. Audit will be completed by Investigation Coordinator status post resident fall that policy/procedure followed according to policy. Safety plans of care will be reviewed per IDCT schedule to assure interventions consistent with assignment sheet. Activity director to audit location of staff in dining room to maintain highest level of supervision all results will be reviewed at QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**
STATE LICENSE NUMBER: **020502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 29 	F 0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0689 SS=G	Continued from page 30	F 0689		
F 0745 SS=E	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 0745	1. MSW has met with resident 26 and 4 and completed progress note regarding same. 2. MSW educated regarding the consistently provided therapeutic social services. 3. Nursing staff will be educated to report any changes with resident's psychosocial well being to social services. 4. NHA/designee will audit social service progress notes to confirm presence of therapeutic social service progress notes in response to a behavioral symptoms and results discussed at QAPI.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 31 Based on review of clinical records and interviews with staff, it was determined that the facility failed to provide therapeutic social services to promote the psychosocial well-being of two of 13 residents reviewed (Resident 26 and Resident 4). Findings include: A review of Resident 26's clinical record revealed admission to the facility on April 10, 2019, with diagnoses which included depression, neuralgia (pain due to a damaged nerve), and anxiety. A Quarterly MDS (Minimum Data Set, an assessment completed periodically to plan resident care) dated September 12, 2022, revealed that Resident 26 was severely cognitively impaired. A nursing note dated February 6, 2023, at 10:04 PM, revealed that the resident became agitated after having her room temporarily changed to allow maintenance staff to perform painting and necessary repairs to the room. According to the nursing	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 32 documentation, once the resident was temporarily relocated, she became agitated and expressed a desire to leave the facility. Resident 26 then made "motions with fingernails to slash wrist" and the resident stated to staff that she wanted to kill herself and the staff. The nursing staff immediately provided one-on-one supervision, assessed the resident's physical environment, and suspended maintenance to the resident's normal room and placed her back into her normally assigned room. Despite staff efforts to redirect the resident, she continued to express desire to die, and exit seek. The physician ordered the resident to be sent to the emergency room for evaluation due to "negative/suicidal statements". A review of social services documentation dated February 7, 2023, at 2:17 PM, indicated that Resident 26 was upset the night prior about having her room temporarily relocated due to maintenance scheduled for her assigned room. According to the documentation, Resident 26 was initially agreeable to the temporary room change, but then became	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 33 agitated, "expressing the desire to leave the facility, and harm herself and/or staff". Resident returned to the facility after being evaluated by the hospital. The resident did not acknowledge the events of last evening, was cheerful, pleasant, and "verbalized no suicidal ideations or any threat to herself or any staff members." Review of clinical record revealed that Resident 26 was evaluated by outside psychiatric services on February 15, 2023, at 930 AM for stated suicidal ideations. The evaluation determined that the resident's current risk factor for suicide was low and that the resident would follow-up with the outside psychiatric services in one month. Recommendations were to add an antidepressant to the resident's current medication regimen. A review of social services documentation dated February 23, 2023, at 2:56 PM, revealed that an invitation was sent to the resident's daughter to attend the next scheduled care plan meeting. There was no documented evidence that the facility's social	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**
STATE LICENSE NUMBER: **020502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 34 service worker had reviewed and/or addressed the consulting psychiatric notes/recommendations to ensure that the resident received appropriate services related to recent verbalizations of self-harm and expressions of distress to ensure the resident's current psychosocial needs were met. A review of social services "quarterly assessment" documentation dated February 28, 2023, at 11:49 AM, revealed that the resident continued on "safety checks by nursing" every 2 hours, "no suicidal ideations noted", and emotional support and TLC offered as needed. The social service documentation did not address the resident's response to the emotional support and "TLC" offered. There was no documented evidence that the facility's designated Social Services Director provided therapeutic social services to Resident 26 in response to the resident's increased agitation, self-harm verbalizations and expressions of distress beginning February 7, 2023.	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 35 Review of Resident 26's care plan for suicidal thoughts/verbalization initiated on February 7, 2023, noted the planned interventions to conduct checks of the resident every shift as directed by physician, schedule psychiatric visits as ordered, contact physician to determine if transfer to ER for emergency treatment warranted if suicidal statement made, assess physical environment for harmful objects and remove those considered to be potentially harmful, contact resident's family regarding verbalized expression, provide for client's basic needs, promoting highest possible level of independent functioning, provide experience/interactions that enhance self-esteem, sense of personal power, safety checks as needed, check room for anything that might be harmful as determined by interdisciplinary care plan team, encourage involvement in life of facility, provide support to resident as needed, one-on-one visits as needed. Review of Resident 26's behavior monitoring flow record dated February 2023 for monitoring of	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 36 verbally aggressive behaviors revealed that on February 24, 25, and 26, 2023, the resident experienced verbally aggressive behaviors. According to the documentation, the staff attempted redirection, one-on-one, activity, toileting, and food and fluids. All interventions were ineffective to resolve the resident's aggressive behaviors. There was no documentation in the resident's clinical record of the provision of therapeutic social services had been provided to the resident in response to the resident's behavioral symptoms. An interview with the Nursing Home Administrator (NHA) on April 13, 2023, at approximately 2:00 PM confirmed that there was no documented evidence that the facility's social service worker provided therapeutic and medically-related social services to Resident 26 to promote her psychosocial well-being. Review of Resident 4's clinical record revealed that the resident was admitted to the facility on March	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 37 16, 2023, with diagnoses to have included Alzheimer's Disease, dementia with psychotic disturbance, unspecified mood disorder, depression, and anxiety disorder. Resident 4's admission Minimum Data Set (MDS) assessment of Resident 4, dated March 23, 2023, revealed that the resident was cognitively intact. Review of nursing progress note completed by Employee 8, a LPN, dated March 20, 2023, at 12:15 PM, revealed that she had been notified by an activity aide that the Resident 4 vocalized that he wanted to kill himself. Employee 8 noted that she immediately assessed the resident and situation and that Resident 4 stated that he was feeling upset and does not like his current situation. The resident stated that he did not have a plan to harm himself. Employee 8 immediately notified the attending physician and was placed on every 30-minute checks, call-bell was removed and provided with a hand bell, and knives were removed from all meal trays for safety.	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**
STATE LICENSE NUMBER: **020502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 38 Additionally, review of the attending physician's assessment dated March 20, 2023, at 4:52 PM, revealed that the physician assessed and indicated that Resident 4 did not seem suicidal and was "more or less seeking attention" and that the resident was at a low risk to hurt and/or kill himself. The physician ordered a psychiatric evaluation, and the resident has a scheduled appointment with psychiatric services on April 19, 2023. Further review of Resident 4's clinical record revealed that the social service worker completed a "Social Evaluation" on March 16, 2023, noting that he was unhappy about placement and wanted to go home "now" and noted that the resident was very anxious. The social service worker noted "Follow-up with patient/family as needed." Further review of the social service worker's social evaluation assessment indicated that an addendum note was added to the evaluation on March 21, 2023. The addendum indicated that Resident 4 had	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 39 an "episode" yesterday when the resident stated that he would kill himself and that he did not like it at the facility and was very anxious. Additionally, it was noted that he was frustrated with his hip fracture and that emotional support was offered and accepted and "seemed" calm that day. Further review of social service's progress notes dated March 22, 2023, at 11:34 AM, revealed that he was very anxious to return to his prior home and that he was frustrated with his current physical status and felt "antsy" and had a poor appetite and was not sleeping well because of "nerves." Additionally, social service progress notes dated March 23, 2023, at 8:44 AM and 3:06 PM, continued to note that the resident "felt down", and had trouble falling asleep and staying asleep, felt tired, and had a poor appetite 12-14 days of the last two weeks. The social service worker indicated that the resident was receiving antidepressant medication to manage depression and was prescribed Xanax (a type of drug called a	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**
STATE LICENSE NUMBER: **020502**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 40 benzodiazepine and used to treat anxiety and panic disorders) to manage his anxiety. There was no further documentation in the resident's clinical record that social services had followed up with Resident 4 after March 23, 2023, until during on site survey ending April 13, 2023, and had consistently provided therapeutic social services to promote the resident's psychosocial well-being and to assist the resident in coping with his current situation and to manage the resident's signs/symptoms of depression. An interview with the Nursing Home Administrator (NHA) on April 13, 2023, at approximately 2:15 PM, confirmed that there was no further documented evidence that the facility's social service worker provided therapeutic and medically-related social services to Resident 4 to promote his psychosocial well-being. 28 Pa. Code 211.5(f)(g)(h) Clinical Records	F 0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0745 SS=E	Continued from page 41 28 Pa. Code 211.16 (a) Social Services.	F 0745		
F 0756 SS=E	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 0756	1. The facility cannot retroactively correct deficient practice in relation to resident 28. MD reviewing resident medication regimen and clarifying diagnoses. 2. Education provided to pharmacist regarding thorough evaluation of medication regimen. 3. Pharmacist will conduct evaluation of the medication regimen utilizing medical record review for supporting clinical rationale for antipsychotic medications prescribed. 4. Audit will be completed x 12 weeks to assure supporting diagnoses for use of antipsychotics and report any irregularities to MD. Results will be reviewed at QAPI.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/08/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=E	Continued from page 42 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=E	Continued from page 43 Based on a review of clinical records and staff interview it was determined that the facility failed to ensure that the pharmacist conducted a drug regimen review at least monthly that included a thorough evaluation of the medication regimen of a resident, including a review of the medical record for supporting clinical rationale for the medications prescribed for one resident out of 28 sampled (Resident 28). Findings include: The Monthly Medication Review (MMR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MMR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. A review of Resident 28's clinical record revealed	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=E	Continued from page 44 that the licensed pharmacist indicated that there were no irregularities relating to the resident' use of Risperidone 0.5 mg (antipsychotic medication) prescription for a diagnosis of Dementia Behavioral Disturbances on the Chronological Record of Monthly Medication Regimen review (MMR) form dated March 18, 2023. Further review of Resident 28's MMR completed by the pharmacist indicated that no irregularities were identified in the resident's drug regimen during the months of February 20, 2023, January 14, 2023, December 17, 2022, November 19, 2022, October 23, 2022, and September 28, 2022. A review of Resident 28's clinical record failed to indicate an active diagnosis of Dementia or dementia behavioral disturbances. A review of Resident 28's Minimum Data Set Assessments (MDS - a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated March 2023,	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=E	Continued from page 45 did not indicate an active diagnosis of dementia. A review of Resident 28's clinical record revealed an active order, at the time of the survey ending April 13, 2023, for Risperdal (Risperidone) 0.5 mg "Give one tablet by mouth twice daily" for anxiety disorder, unspecified. Interview with the Nursing Home Administrator on April 12, 2023, at 10:45 a.m. confirmed that Resident 28 did not have a current diagnosis of Dementia or supporting diagnosis for the use of the antipsychotic drug, Risperdal and the pharmacist failed to identify the irregularity in the resident's drug regimen. 28 Pa. Code 211.9 (k) Pharmacy services. 28 Pa. Code 211.12 (c) Nursing services. 28 Pa. Code 211.2(a) Physician services	F 0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0756 SS=E	Continued from page 46 28 Pa. Code 211.5(h) Clinical records	F 0756		
F 0761 SS=D	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	1. The facility corrected deficient practice in relation to Resident 6 at time of survey. Resident A1 discharged prior to survey. 2. Policy reviewed for dating/discarding of medication bottles. 3. Nursing staff will be educated regarding policy. 4. DON/Designee will audit nursing cart 2x weekly x 12 weeks to verify compliance with policy with results reviewed at QAPI.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 47	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 48 Based on observations and a review of select facility policy and staff interviews it was determined that the facility failed to label multi dose medication bottles with open dates to ensure acceptable time frames for use on one medication cart out of two medication carts observed (blue hallway). Findings include: According to the National Association of Boards of Pharmacy, Uniform Prescription Labeling Requirements, indicate that critical information on prescription labels include the "Use by" date, which is the Date by which medication should be used, not expiration date of medication or expiration date of prescription.	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 49 During an interview April 12, 2023, at 11 AM, the Director of Nursing stated that multiple dose eye drop bottles are to be discarded 30 days after opening. In addition, nursing staff are to write the date opened on the bottle when first opened for use. Observation conducted on April 12, 2023, at 9:30 a.m. of the blue hallway medication cart revealed 1 bottle of Prednisone-Bromfernac eye drops belonging to Resident 6 with no open date and an opened bottle of Moisture eye drops belonging to Resident A1 with no open date. The observation was confirmed at the time of the observation by Employee 7 (LPN). Interview with Employee 2, Licensed Practical Nurse, at this time, confirmed	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 50 that the medications were outdated and should been disposed of and not left in the cart for continued resident use. An interview with the Nursing Home Administrator on April 13, 2023, at 2 PM confirmed that the Ophthalmic medication should have had an open date. 28 Pa. Code 211.9 (a)(1)(k) Pharmacy Services 28 Pa. Code 211.12 (a)(d)(3)(5) Nursing services	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0761 SS=D	Continued from page 51	F 0761		
F 0812 SS=F	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1. Identified concerns in the Dietary department and unit panty area were addressed at time of survey. 2. Education was provided to Dietary supervisor and nursing staff regarding maintaining food safety requirements. 3. Additional education provided to dietary cleaner along with food safety requirements education with dietary staff. Refrigerator removed from pantry area and replaced. Defrosting of freezers reviewed with nursing/housekeeping staff. 4. Audit will be completed by Dietary supervisor 3x weekly x 12 weeks to assure compliance with food safety standards. Audit will be completed by RD weekly x 6 months to assure supervisor compliance	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/09/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 52	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 53 Based on observation and staff interview, it was determined that the facility failed to maintain acceptable practices for the storage and service of food to prevent the potential for contamination and microbial growth in food, which increased the risk of food-borne illness. Findings include: Food safety and inspection standards for safe food handling indicate that everything that comes in contact with food must be kept clean and food that is mishandled can lead to foodborne illness. Safe steps in food handling, cooking, and storage are essential in preventing foodborne illness. You cannot always see, smell, or taste harmful bacteria that may cause illness according to the USDA (The United States Department of Agriculture, also	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 54 known as the Agriculture Department, is the U.S. federal executive department responsible for developing and executing federal laws related to food). Review of the current facility policy entitled "Policy for Dating Leftovers and Dairy Products" indicated that all leftovers will be put in containers or plastic bags and dated and then used within 72-hours. Dry storage area, walk-in coolers and walk-in freezers, and coolers will be checked and logged for cleanliness and for dating of items at the beginning and at the end of operation by the supervisor or designee. Review of the current facility policy entitled "Container Policy: Resident Food Storage" indicated that resident items are to be placed in a closed container and the	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 55 container will be labeled with the resident's name, date, and room number. Perishable food will be kept in the unit refrigerator no longer than consumably desirable, as determined by the nursing staff. Observation in the reach-in tray line refrigerator that there was a stainless-steel pan of cherry fruited gelatin that was dated April 7, 2023, and scheduled for service on April 8, 2023, and on April 11, 2023. The food service manager stated that the prepared item should be discarded in 3-days and confirmed that the fruited gelatin should not be served on April 11, 2023 (> 3-day). Observation in the tray line cooler revealed that there was a deep stainless pan of lettuce and 7 containers of foods	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 56 intended for the salad bar, which were not dated. There were three plastic clamshell containers of scones that were not dated. There were three shallow trays (one pizza, one brussels sprouts, and one with potatoes) that were not dated and a half shallow stainless pain that contained cherry gelatin that was uncovered and open to air. Observations in the walk-in dairy cooler revealed a 5 lb. container of cottage cheese that was opened and dated April 2, 2023. The manager confirmed the container should have been discarded. Observations of the dry storage area revealed a garbage can with trash inside that did not have a lid to cover the trash. In the area that housed snacks and cases	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 57 of canned soda, there was a bucket on the top shelf of a wired rack and placed underneath an open ceiling tile that exposed a repaired broken pipe. The dietary manager stated there was a broken sewage/waste disposal pipe and that it was repaired and that the bucket was placed there in case of another break. Observation of the area that housed dietary's paper products revealed that there were several cases of product stored too close to the ceiling. Observation of the walk-in produce cooler revealed that there was a 12.84-ounce bottle of balsamic glaze that was not dated Observation revealed an accumulation of dust in the light fixture and vent grates	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 58 with cobwebs present on the hood above the stove. The ceiling fan inside of the dish room had an accumulation of dust and debris. During an observation of the unit pantry area on April 11, 2023, at 10:55 AM, revealed that the following concerns were identified: there was a container of cheesecake that was dated March 22, 2023, (expired by 20-days), a jar of nacho dip that was not labeled or dated, an open jar of cheese dip that was not labeled or dated, a packet of sour cream with a manufacturer's expiration date of April 10, 2023 (expired by 4-days), and a quart of half and half with a listed expiration date of January 23, 2023. A significant build-up of ice crystals was	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 59 observed in the freezer and there was a package of frozen pizza that had significant ice crystals inside of the packaging and was not dated. Interview with the Nursing Home Administrator on April 12, 2023, at 1:15 PM, confirmed that the dietary department and unit pantry area were to be maintained in a sanitary manner and that food/beverages should be stored in a sanitary manner. 28 Pa. Code 207.2(a) Administrator's responsibility 28 Pa Code 211.6(c) Dietary services	F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0813 SS=E	483.60(i)(3) Personal Food Policy §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by:	F 0813	1. Identified food items were discarded at time of inspection. 2. Resident Food Storage policy was updated to include expected discard date. 3. Nursing/activity staff educated on change to policy. 4. NHA/designee will audit outside resident personal food to assure compliance with policy 2 x weekly x 12 weeks with results reviewed at QAPI.	Completion Date: **06/01/2023** Status: **APPROVED** Date: **05/05/2023**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0813 SS=E	Continued from page 61 Based on select facility policy review and staff interview it was determined that the facility failed to develop and implement a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling and consumption of foods. Findings include: Review of the current facility policy entitled "Container Policy: Resident Food Storage" that was last reviewed by the facility on December 22, 2022, indicated that resident items are to be placed in a closed container and the container will be labeled with the resident's name, date, and room number. Perishable food will be kept in the unit refrigerator no longer than consumably desirable, as determined by	F 0813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: 00 B. WING:	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET** **SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0813 SS=E	Continued from page 62 the nursing staff. During an observation of the unit pantry area on April 11, 2023, at 10:55 AM, revealed that there were several food items brought in by residents' family/visitors that were kept past the manufacturers' identified expiration date on the packaging. The facility failed to fully develop and implement a policy that addressed sanitary food storage practices for personal food to include expected discard dates. Interview with the regional Nursing Home Administrator (NHA) on April 13, 2023, at 1:30 PM, failed to provide documented evidence that the current facility outside food policy included safe and sanitary storage, handling, and consumption of the	F 0813		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395285	A. BLDG: __00_____ B. WING: _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
BARNES-KASSON COUNTY HOSPITAL SNF STATE LICENSE NUMBER: **020502**	**2872 TURNPIKE STREET SUSQUEHANNA, PA 18847**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0813 SS=E	Continued from page 63 food. Refer F812 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 211.10(a) Resident care policies	F 0813		

Certified End Page

BARNES-KASSON COUNTY HOSPITAL SNF

STATE LICENSE NUMBER: 020502

SURVEY EXIT DATE: 04/13/2023

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeane Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen, MD, FAAP
Acting Secretary of Health

pennsylvania
DEPARTMENT OF HEALTH

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY